Complete Summary

GUIDELINE TITLE

Low back - lumbar & thoracic (acute & chronic).

BIBLIOGRAPHIC SOURCE(S)

Work Loss Data Institute. Low back - lumbar & thoracic (acute & chronic). Corpus Christi (TX): Work Loss Data Institute; 2007 Jul 5. 393 p. [543 references]

GUIDELINE STATUS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.
- May 2, 2007, Colchicine: Immediate drug recall for all strengths, sizes and lots of ApothéCure compounded injectable Colchicine sold within the last year due to recent deaths associated with the use of the product.
- June 15, 2005, Non-Steroidal Anti-Inflammatory Drugs (NSAIDs): U.S. Food and Drug Administration (FDA) recommended proposed labeling for both the prescription and over the counter (OTC) NSAIDs and a medication guide for the entire class of prescription products.
- April 7, 2005, Non-steroidal anti-inflammatory drugs (NSAIDS) (prescription and OTC, including ibuprofen and naproxen): FDA asked manufacturers of prescription and non-prescription (OTC) non-steroidal anti-inflammatory drugs (NSAIDs) to revise their labeling to include more specific information about potential gastrointestinal (GI) and cardiovascular (CV) risks.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Work-related low back pain

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Chiropractic
Family Practice
Internal Medicine
Orthopedic Surgery
Physical Medicine and Rehabilitation
Surgery

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Health Plans
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To offer evidence-based step-by-step decision protocols for the assessment and treatment of workers' compensation conditions

TARGET POPULATION

Workers with low back pain

INTERVENTIONS AND PRACTICES CONSIDERED

The following interventions/procedures were considered and recommended as indicated in the original guideline document:

1. Activity restrictions/work modifications
2. Aerobic exercise
3. Age adjustment
4. Antidepressants in chronic cases
5. Anti-inflammatory medications (e.g., ibuprofen)
6. Aquatic therapy (as an optional form of exercise therapy)
7. Back schools
8. Behavioral treatment
9. Chiropractic/manipulation
10. Cold/heat packs for acute pain
11. Conservative care (first six months)
12. Differential diagnosis
13. Discectomy/laminectomy
14. Electromyography (needle, not surface)
15. Epidural steroid injections (ESIs) (treatment and diagnostic)
16. Evoked potential studies
17. Exercise
18. Facet joint diagnostic blocks (injections) prior to facet neurotomy
19. Facet joint pain, signs and symptoms
20. Fear-avoidance beliefs questionnaire (FABQ)
21. Fluoroscopy (for ESIs)
22. Hardware injection block for diagnostic evaluation of failed back surgery syndrome
23. Heat therapy
24. Herbal medicines
25. Home health services
26. H-reflex tests
27. Implantable drug-delivery systems (IDDSs) (as an end-stage treatment alternative)
28. Kyphoplasty
29. Lumbar extension exercise equipment
30. Magnetic resonance imaging (MRI)
31. Massage
32. McKenzie method
33. Microdiscectomy
34. Muscle relaxants for acute cases
35. Myelography
36. Nonprescription medications (e.g., acetaminophen, aspirin, ibuprofen) for early use only
37. Occupational/physical therapy
38. Patient education for treatment
39. Percutaneous vertebroplasty
40. Psychological screening prior to surgery
41. Return to work and regular activities
42. Segmental rigidity (diagnosis)
43. Shoe insoles/shoe lifts
44. Spinal cord stimulation (SCS) for selected patients
45. Stretching (as part of an exercise program)
46. Work conditioning/work hardening
47. Yoga

The following interventions/procedures were considered optional:

Shoe insoles/shoe lifts

The following interventions/procedures are under study and are not specifically recommended:

1. Acupressure
2. Adhesiolysis, spinal endoscopic
3. Back brace/corsets/lumbar supports for treatment
4. Bone-growth stimulators
5. Colchicine
6. Electromagnetic pulsed therapy
7. Ergonomic interventions for primary prevention
8. Facet joint intra-articular injections (therapeutic blocks)
9. Facet rhizotomy/facet joint radiofrequency neurotomy
10. Feldenkrais
11. Gabapentin
12. Magnetic resonance (MR) neurography
13. Mattress firmness
14. Percutaneous adhesiolysis/epidural neuroplasty
15. Percutaneous electrical nerve stimulation (PENS)

The following interventions/procedures were considered, but are not recommended:

1. Acupuncture
2. Back brace/corsets/lumbar supports for prevention
3. Bed rest
4. Biofeedback
5. Bone scan
6. Botulinum toxin (Botox)
7. Bupropion for low back pain
8. Chemonucleolysis (chymopapain)
9. Computed tomography (CT) and CT myelography
10. Cutaneous laser treatment
11. Current perception threshold (CPT) testing
12. Delayed treatment
13. Device for intervertebral assisted motion (DIAM)
14. Diathermy
15. Disc prosthesis/replacement
16. Discography
17. Dynamic neutralization system (Dynesys)
18. Epidural steroid injections, "series of three"
19. Facet-joint injections, thoracic
20. Facet joint medial branch blocks for therapy
21. Flexibility evaluation
22. Functional anesthetic discography
23. F-wave tests
24. Fusion (spinal, endoscopic)
25. Hospitalization except for major trauma
26. H-wave stimulation (devices)

27. Interferential therapy
28. Intradiscal electrothermal annuloplasty (IDET)
29. Intradiscal steroid injection
30. Iontophoresis
31. Ligamentous injections
32. Low level laser therapy (LLLT)
33. Lumbar supports for prevention
34. Magnet therapy
35. Manipulation under anesthesia (MUA)
36. Microcurrent electrical stimulation (MENS devices)
37. NC-stat nerve conduction studies/nerve conduction studies (NCS)
38. Neuromuscular electrical stimulators (NMES) (except for patients with specific criteria)
39. Neuroreflexotherapy
40. Nucleoplasty
41. Opioids/narcotics (except for short use with severe cases)
42. Oral corticosteroids
43. Orthotrac vest
44. Percutaneous discectomy (PCD)
45. Percutaneous endoscopic laser discectomy (PELD)
46. Percutaneous intradiscal radiofrequency (thermocoagulation)
47. Percutaneous neuromodulation therapy (PNT)
48. Powered traction devices
49. Prolotherapy, also known as sclerotherapy
50. Radiography in the absence of red flags
51. Single photon emission computed tomography (SPECT)
52. Standing MRI
53. Surface electromyography (SEMG)
54. Sympathetic therapy
55. Thermography (infrared stress thermography)
56. Traction
57. Transcutaneous electrical neurostimulation (TENS)
58. Transplantation, intravertebral disc
59. Trigger point injections in the absence of myofascial pain syndrome
60. Tumor necrosis factor modifiers
61. Ultrasound (diagnostic and therapeutic)
62. Vertebral axial decompression (VAX-D)/powered traction devices
63. Videofluoroscopy

MAJOR OUTCOMES CONSIDERED

- Reliability and value of diagnostic assessments
- Effectiveness of treatment in relieving pain and restoring normal function

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Work Loss Data Institute (WLDI) conducted a comprehensive medical literature review (now ongoing) with preference given to high quality systematic reviews, meta-analyses, and clinical trials published since 1993, plus existing nationally recognized treatment guidelines from the leading specialty societies. WLDI primarily searched MEDLINE and the Cochrane Library. In addition, WLDI also reviewed other relevant treatment guidelines, including those in the National Guideline Clearinghouse, as well as state guidelines and proprietary guidelines maintained in the WLDI guideline library. These guidelines were also used to suggest references or search terms that may otherwise have been missed. In addition, WLDI also searched other databases, including MD Consult, eMedicine, CINAHL, and conference proceedings in occupational health (i.e. American College of Occupational and Environmental medicine [ACOEM]) and disability evaluation (i.e. American Academy of Disability Evaluating Physicians [AADEP], American Board of Independent Medical Examiners [ABIME]). Search terms and questions were diagnosis, treatment, symptom, sign, and/or body-part driven, generated based on new or previously indexed existing evidence, treatment parameters and experience.

In searching the medical literature, answers to the following questions were sought: (1) If the diagnostic criteria for a given condition have changed since 1993, what are the new diagnostic criteria? (2) What occupational exposures or activities are associated causally with the condition? (3) What are the most effective methods and approaches for the early identification and diagnosis of the condition? (4) What historical information, clinical examination findings or ancillary test results (such as laboratory or x-ray studies) are of value in determining whether a condition was caused by the patient's employment? (5) What are the most effective methods and approaches for treating the condition? (6) What are the specific indications, if any, for surgery as a means of treating the condition? (7) What are the relative benefits and harms of the various surgical and non-surgical interventions that may be used to treat the condition? (8) What is the relationship, if any, between a patient's age, gender, socioeconomic status and/or racial or ethnic grouping and specific treatment outcomes for the condition? (9) What instruments or techniques, if any, accurately assess functional limitations in an individual with the condition? (10) What is the natural history of the disorder? (11) Prior to treatment, what are the typical functional limitations for an individual with the condition? (12) Following treatment, what are the typical functional limitations for an individual with the condition? (13) Following treatment, what are the most cost-effective methods for preventing the recurrence of signs or symptoms of the condition, and how does this vary depending upon patient-specific matters such as underlying health problems?

Criteria for Selecting the Evidence

Preference was given to evidence that met the following criteria: (1) The article was written in the English language, and the article had any of the following attributes: (2) It was a systematic review of the relevant medical literature, or (3) The article reported a controlled trial – randomized or controlled, or (4) The article reports a cohort study, whether prospective or retrospective, or (5) The article reports a case control series involving at least 25 subjects, in which the assessment of outcome was determined by a person or entity independent from

the persons or institution that performed the intervention the outcome of which is being assessed.

More information about the selection of evidence is available in "Appendix. ODG Treatment in Workers' Comp. Methodology description using the AGREE instrument" (see "Availability of Companion Documents" field).

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Ranking by Type of Evidence

1. Systematic Review/Meta-Analysis
2. Controlled Trial-Randomized (RCT) or Controlled
3. Cohort Study-Prospective or Retrospective
4. Case Control Series
5. Unstructured Review
6. Nationally Recognized Treatment Guideline (from www.guideline.gov)
7. State Treatment Guideline
8. Other Treatment Guideline
9. Textbook
10. Conference Proceedings/Presentation Slides

Ranking by Quality within Type of Evidence

a. High Quality
b. Medium Quality
c. Low Quality

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Work Loss Data Institute (WLDI) reviewed each article that was relevant to answering the question at issue, with priority given to those that met the following criteria: (1) The article was written in the English language, and the article had any of the following attributes: (2) It was a systematic review of the relevant medical literature, or (3) The article reported a controlled trial – randomized or controlled, or (4) The article reported a cohort study, whether prospective or retrospective, or (5) The article reported a case control series

involving at least 25 subjects, in which the assessment of outcome was determined by a person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed.

Especially when articles on a specific topic that met the above criteria were limited in number and quality, WLDI also reviewed other articles that did not meet the above criteria, but all evidence was ranked alphanumerically (see the Rating Scheme of the Strength of Evidence field) so that the quality of evidence could be clearly determined when making decisions about what to recommend in the Guidelines. Articles with a Ranking by Type of Evidence of Case Reports and Case Series were not used in the evidence base for the Guidelines. These articles were not included because of their low quality (i.e., they tend to be anecdotal descriptions of what happened with no attempt to control for variables that might effect outcome). Not all the evidence provided by WLDI was eventually listed in the bibliography of the published Guidelines. Only the higher quality references were listed. The criteria for inclusion was a final ranking of 1a to 4b (the original inclusion criteria suggested the methodology subgroup), or if the Ranking by Type of Evidence was 5 to 10, the quality ranking should be an "a."

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The guideline developers reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Prior to publication, select organizations and individuals making up a cross-section of medical specialties and typical end-users externally reviewed the guideline.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary. The recommendations that follow are based on the previous version of the guideline.

Identify Radicular Signs

- First visit: may be with Primary Care Physician MD/DO (50%), Orthopedist (33%), or Chiropractor (17%)
- Determine presence or absence of radiculopathy:
    - Medical history
    - Sensation: Feeling pain radiating below the knee (calf or lower), not just referred pain (pain radiating to buttocks or thighs), and dermatological sensory loss
    - Straight leg raising test (sitting and supine), productive of leg pain
    - Motor strength and deep tendon reflexes
    - Document flexibility/range of motion (ROM) (fingertip test), muscle atrophy (calf measurement), local areas of tenderness, visual pain analog, sensation alternation
    - **Note**: Radiculopathy is often over-diagnosed. For unequivocal evidence of radiculopathy, refer to the American Medical Association *(AMA) Guides to the Evaluation of Permanent Impairment*, 5th Edition, page 382-383.
- Rule out "red flag" diagnoses, including diagnostic studies, for specialist referral:
    - Cauda Equina Syndrome (Schedule emergency procedure) (Refer to the original guideline document for International Classification of Diseases, Ninth Revision [ICD-9] codes for this and other diagnoses)
    - Fracture, Compression fracture, Dislocation, Wound
    - Cancer, Infection
    - Dissecting/Ruptured Aortic Aneurysm
    - Others (prostate problems, endometriosis/gynecological disorders, urinary tract infections, and renal pathology)
    - **Note**: This guideline should not be used to suggest appropriate procedures for other conditions or comorbidities. When the treating doctor suspects any other diagnosis, they may decide what necessary testing should be performed, which may include laboratory tests such as erythrocyte sedimentation rate (ESR), complete blood count (CBC), and urinalysis (UA) to screen for nonspecific medical diseases (especially infection and tumor) of the low back.

Without Radiculopathy (90% of cases)

- Also first visit (day 1):
    - Prescribe decreased activity, if necessary, based on severity and difficulty of job, limited passive therapy with heat/ice (3 to 4 times/day), stretching/exercise (training by physical therapist OK), appropriate analgesia (i.e., acetaminophen) and/or anti-inflammatory (i.e., ibuprofen) [*Benchmark cost: $14*], back to work except for severe cases in 72 hours, possibly modified duty. Avoid bed rest.
    - No x-rays unless significant trauma (e.g., a fall)
    - If muscle spasms, then consider muscle relaxant with limited sedative side effects [*Benchmark cost: $44*]

      (**Note**: The purpose of muscle relaxants is to facilitate return to activity, but muscle relaxants have not been shown to be more effective than non-steroidal anti-inflammatory drugs [NSAIDs].)

    - REASSURE PATIENT: patient education - common problem (90% of patients recover spontaneously in 4 weeks)

Official Disability Guidelines (ODG) Return-To-Work Pathways (*lumbar sprain and lumbago*)

Modified Duty --

Mild, (Grade I)[1], clerical/modified work: 0 days

Severe, (Grade II-III)[1], clerical/modified work: 3 days

(See *ODG Capabilities & Activity Modifications for Restricted Work* under "Work" in the Procedure Summary for Ergonomic accommodations of the original guideline document)

[1]**Definition of Sprain/Strain Severity Grade**: In general, a Grade I or mild sprain/strain is caused by overstretching or slight tearing of the ligament/muscle/tendon with no instability, and a person with a mild sprain usually experiences minimal pain, swelling, and little or no loss of functional ability. Although the injured muscle is tender and painful, it has normal strength. A Grade II sprain/strain is caused by incomplete tearing of the ligament/muscle/tendon and is characterized by bruising, moderate pain, and swelling, and a Grade III sprain/strain means complete tear or rupture of a ligament/muscle/tendon. A sprain is a stretch and/or tear of a ligament (a band of fibrous tissue that connects two or more bones at a joint). A strain is an injury to either a muscle or a tendon (fibrous cords of tissue that connect muscle to bone).

- Second visit (day 3 to 10 - about 1 week after first visit or sooner because delayed treatment is not recommended)
    - Document progress (flexibility, areas of tenderness, motor strength, straight leg raise--sitting and supine).
    - If still 50% disabled then consider referral for exercise/instruction/manual therapy [*Benchmark cost: $250*]: Options are physical therapist, chiropractor, massage therapist, or occupational therapist (3 visits in first week), or by treating DO/MD (Choose providers supporting active therapy and not just passive modalities. The focus of treatment should not be symptom reduction, but improving function with a goal to return to work.) Consider screening for psychosocial symptoms in cases with expectations of delayed recovery.
    - Discontinue muscle relaxant.

ODG Return-To-Work Pathways (*lumbar sprain and lumbago*)

Manual Work --

Mild, manual work: 7 to 10 days

Severe, manual work: 14 to 17 days

- Third visit (day 10 to 17 - about 1 week after second visit)
    - Document progress.
    - Prescribe muscle-conditioning exercises.
    - At this point 66% to 75% should be back to regular work.
    - While not indicated in the absence of red flags, if still disabled, then consider imaging study (anterior-posterior [AP]/lateral 2-view x-ray of

lumbar) [*Benchmark cost: $150*] to rule out tumor, fracture, osteoporosis, myelopathy
    - Maintain therapy, continue focus on active therapy and not passive modalities, 2 visits in next week, teach home exercises
    - End manual therapy at 4 weeks (1 visit in last week)

ODG Return-To-Work Pathways (*lumbar sprain and lumbago*)

Manual & Heavy Manual Work --

Severe, manual work: 14 to 17 days

Severe, heavy manual work: 35 days

With Radiculopathy (10% of cases)

- Also first visit (day 1)
    - Same as non-radicular

ODG Return-To-Work Pathways (*intervertebral disc disorders*)

Disc bulge --

Mild cases with back pain, avoid strenuous activity: 0 days

Herniated disc --

Initial conservative medical treatment, clerical/modified work: 3 days

- Second visit (day 3-10 - about 1 week after first visit)
    - Same as non-radicular, but
    - Reassure, but if increased numbness or weakness of either leg, get back to provider in one day
    - Consider referral to nonsurgical musculoskeletal physician (Orthopedist/Physical Medicine/Sports Medicine).
- Third visit (day 10 to 17 - about 1 week after second visit)
    - Same as non-radicular, but
    - About 50% can be back at modified duty.
    - If improvement, then add strengthening exercises, increased activity
- Fourth visit (day 21 to 28 - about 1 to 2 weeks after third visit)
    - Document, if no improvement then:
    - First magnetic resonance imaging (MRI) (about 3% of total cases, or 30% of radicular cases) to confirm extruded disk with nerve root displacement ($\geq$1 month conservative therapy) [*Benchmark cost: $1,600*]
    - MRI or computed tomography (CT) **not** indicated without obvious clinical level of nerve root dysfunction, clear radicular findings, or before 3 to 4 weeks

- EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious.
- Consider an epidural steroid injection (ESI) for severe cases hoping to avoid surgery [*Benchmark cost: $676*] (**Note**: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, but this treatment alone offers no significant long-term functional benefit.)
- If psychological factors retarding recovery are suspected, possibly refer to psychologist for testing. [*Benchmark cost: $540*]
- Education: Consider back school as an option, if available
- If no improvement 7 to 14 days after the first ESI, consider prescribing 2nd ESI [*Benchmark cost: $615*]; there should be a maximum of two ESIs, and the second ESI can be 7 to 14 days after the first, depending upon the patient's response and functional gain.

ODG Return-To-Work Pathways (*intervertebral disc disorders*)

Initial conservative medical treatment, manual work: 28 days

Initial conservative medical treatment, regular work if cause of disability: 84 days

- Surgery (three months or more -- after appropriate work-up and consultation, concordance between radicular findings on radiologic evaluation and physical exam findings) (about 2% of total cases, or 20% of radicular cases) (See also *ODG Indications for Surgery™ -- Discectomy* in the Procedure Summary of the original guideline document). Unequivocal objective findings are required based on neurological examination and testing.
    - Refer to fellowship trained Spine Surgeon: Neurosurgeon (50%), Orthopedist (50%)
    - Before surgery, screen for psychological symptoms that could affect surgical outcome (e.g., substance abuse, child abuse, work conflicts, somatization, verbalizations, attorney involvement, smoking).
    - Review options/outcomes with patient, let patient be part of decision making.
    - Simple discectomy/laminectomy, minimally invasive [*Benchmark cost: $17,400*]
    - Post-operative pain, walking exercises, physical therapy

ODG Return-To-Work Pathways (*intervertebral disc disorders*)

Discectomy, clerical/modified work: 28 days

Discectomy, manual work: 56 days

Discectomy, heavy manual work: 126 days to indefinite

Laminectomy, clerical/modified work: 28 days

Laminectomy, manual work: 70 days

Laminectomy, heavy manual work: 105 days to indefinite

- Failure to recover: See the Procedure Summary (in the original guideline document) for options that may be available, along with links to the medical evidence. Also see the Chronic Pain Chapter.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

During the comprehensive medical literature review, preference was given to high quality systematic reviews, meta-analyses, and clinical trials over the past ten years, plus existing nationally recognized treatment guidelines from the leading specialty societies.

The heart of each Work Loss Data Institute guideline is the Procedure Summary (see the original guideline document), which provides a concise synopsis of effectiveness, if any, of each treatment method based on existing medical evidence. Each summary and subsequent recommendation is hyper-linked into the studies on which they are based, in abstract form, which have been ranked, highlighted and indexed.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

These guidelines unite evidence-based protocols for medical treatment with normative expectations for disability duration. They also bridge the interests of the many professional groups involved in diagnosing and treating work-related low back pain.

POTENTIAL HARMS

Muscle relaxants have potential side effects, including drowsiness in up to 30 percent of patients.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The Treatment Planning sections outline the most common pathways to recovery, but there is no single approach that is right for every patient and these protocols do not mention every treatment that may be recommended. See the Procedure Summaries (in the original guideline document) for complete lists of the various options that may be available, along with links to the medical evidence.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Patient Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Work Loss Data Institute. Low back - lumbar & thoracic (acute & chronic). Corpus Christi (TX): Work Loss Data Institute; 2007 Jul 5. 393 p. [543 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 (revised 2007 Jun 12)

GUIDELINE DEVELOPER(S)

Work Loss Data Institute - Public For Profit Organization

SOURCE(S) OF FUNDING

Not stated

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Editor-in-Chief, Philip L. Denniston, Jr. and Senior Medical Editor, Charles W. Kennedy, MD, together pilot the group of approximately 80 members. See the ODG *Treatment in Workers Comp* Editorial Advisory Board.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

There are no conflicts of interest among the guideline development members.

GUIDELINE STATUS

Note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

GUIDELINE AVAILABILITY

Electronic copies of the updated guideline: Available to subscribers from the Work Loss Data Institute Web site.

Print copies: Available from the Work Loss Data Institute, 169 Saxony Road, Suite 210, Encinitas, CA 92024; Phone: 800-488-5548, 760-753-9992, Fax: 760-753-9995; www.worklossdata.com.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Background information on the development of the Official Disability Guidelines of the Work Loss Data Institute is available from the Work Loss Data Institute Web site.
- Appendix. ODG Treatment in Workers' Comp. Methodology description using the AGREE instrument. Available to subscribers from the Work Loss Data Institute Web site.

PATIENT RESOURCES

The following is available:

- Appendix B. ODG Treatment in Workers' Comp. Patient information resources. 2006.

Electronic copies: Available to subscribers from the Work Loss Data Institute Web site.

Print copies: Available from the Work Loss Data Institute, 169 Saxony Road, Suite 210, Encinitas, CA 92024; Phone: 800-488-5548, 760-753-9992, Fax: 760-753-9995; www.worklossdata.com.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on February 2, 2004. The information was verified by the guideline developer on February 13, 2004. This NGC summary was updated by ECRI on March 28, 2005, January 3, 2006, April 11, 2006, November 10, 2006, and March 30, 2007. This summary was updated by ECRI Institute on May 17, 2007 following the U.S. Food and Drug advisory on Colchicine. This NGC summary was updated by ECRI Institute on August 28, 2007. This summary was updated by ECRI Institute on October 31, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs.

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Date Modified: 9/15/2008